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CMOs: Navigating Healthcare's Stormy Seas

AND

Material Risks in Reserves

PIAA

Chief Medical Officers Help Insurers Navigate Today's Stormy Healthcare Environment

Insights on the Impact of EHRs and HIT, Challenges of Insuring Different Generations of Physicians, and More

The role of chief medical officer (CMO) within hospitals and healthcare systems has been established for many years. But for medical professional liability (MPL) insurers, it is relatively new. In the hospital setting, the CMO is typically responsible for providing oversight and medical expertise for all clinical services. In concert with the entity's executive team, the CMO develops and promotes organizational goals and objectives and assures that quality, well-coordinated healthcare services are provided to its patients.

In the MPL setting, the CMO position, in part a consequence of the recent introduction of the position, plays a more fluid, evolving role in ensuring patient safety and the optimal use of the company's resources.

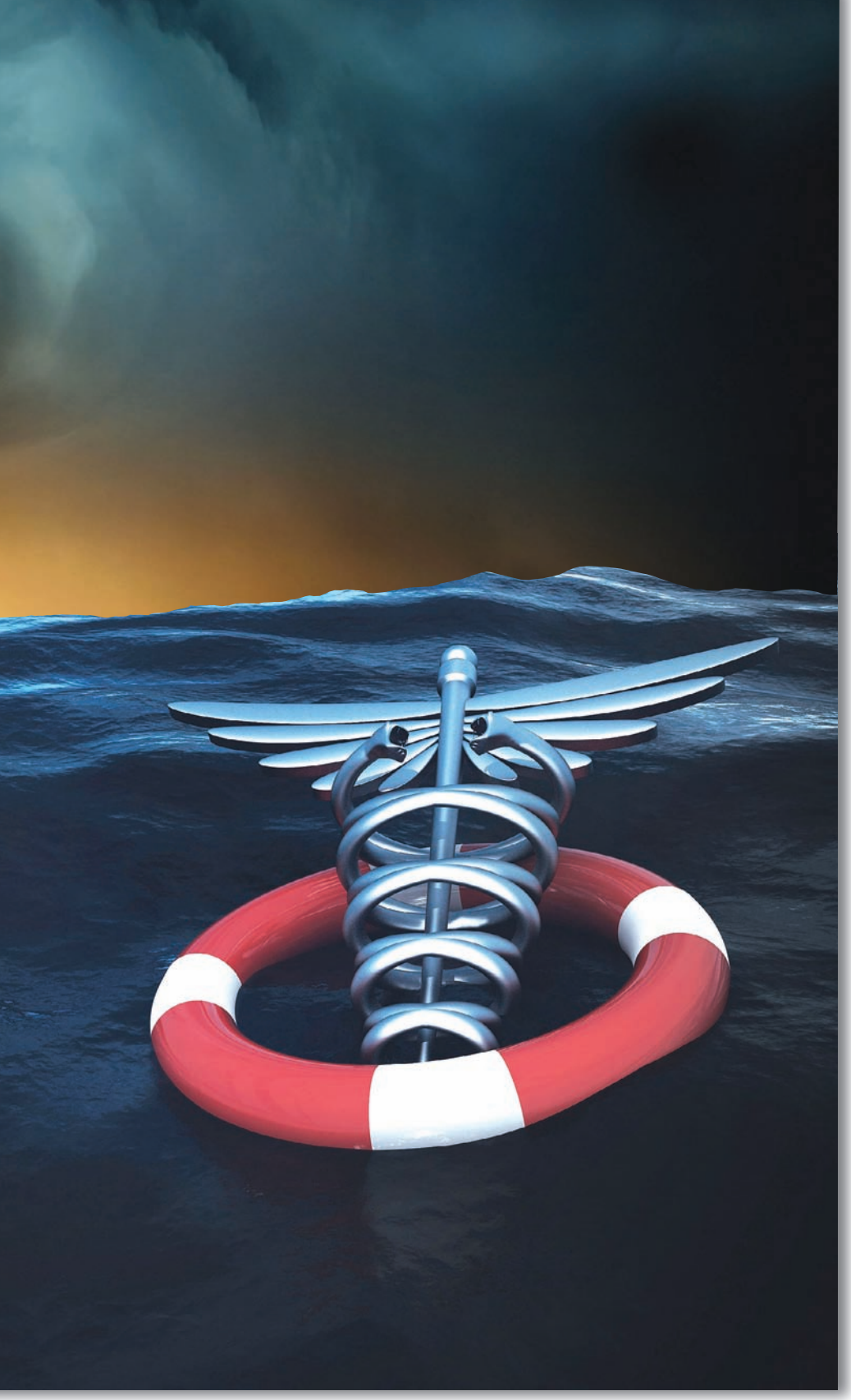
Because of the important contributions made by incumbents in this emerging position in many MPL organizations, *Inside Medical Liability* is presenting a two-part series of articles that explore the role and accomplishments of CMOs. In Part One, we discuss with CMOs some key trends now shaping the volatile healthcare landscape. In Part Two, to be published in the Second Quarter issue, we take a closer look at the evolving role of the CMO.

To get a sense of the CMO's perspective on some important topics in MPL, *Inside Medical Liability* spoke with four CMOs who had participated in the recent PIAA CMO Roundtable in New Orleans:

- **Luke Sato, MD,** Senior Vice President and Chief Medical Officer, CRICO and Assistant Clinical Professor of Medicine at Harvard Medical School
- **Laurie Drill-Mellum, MD MPH,** Chief Medical Officer, MMIC Group
- **Dana Welle, MD, DO, JD, FACOG, FACS,** Chief Medical Officer, Stanford University Medical Network Risk Authority, LLC (The Risk Authority)
- **Graham Billingham, MD, FACEP, FAAEM,** Chief Medical Officer, Medical Protective Company

In particular, we asked about two issues of emerging importance: the impact of electronic health records (EHRs) and HIT in medicine and MPL and the challenges in insuring different generations of physicians.

We got some fascinating and thoughtful answers. Please read on, to find out for yourself.



EHRs and HIT

IML: What are the major impacts of EHRs and HIT on healthcare professionals, and are these technologies improving risk and reducing exposure for healthcare professionals?

Sato: EHRs and HIT are changing the delivery of healthcare for the patients. One of the things that we're seeing, at least within some of the organizations that we insure, is that they're using EHRs and HIT, via the patient portals, to actually provide access to patients so they can look at their own visit notes.

I think that's a tremendous opportunity, because the patient can add another set of eyes to look at their medical record. It's also a great opportunity to engage the patient or their family. Issues that may have been discussed but missed, dropped, or haven't been in the line of sight of the physician the patients can bring up.

From our perspective, this can potentially be utilized as a tool to mitigate missed and delayed diagnosis claims. It's a tremendous opportunity and we would like to see this spread and implemented much more pervasively.

Several preliminary studies have examined the impact of Open Notes where there were myths that clinicians, initially, were fearful that, by opening up these notes to patients, they were going to be bombarded with questions, change their workflow dramatically, increase risk, and so forth. But so far, the evidence has indicated that's not true at all. Some clinicians are actually asking—Is the patient portal really on? They haven't seen a dramatic increase in e-mail traffic from their patients.

We're still new in this game, so this technology could potentially be used down the road in a negative fashion against the clinicians but right now, our hypothesis is that the benefits seem to outweigh the risks.

Welle: In terms of improving risk and reducing exposure, I don't know if I can really answer that question, because we don't have enough information to decide about it yet. I know that we have seen some claims around the EHR, but I don't know nationally what that might look like. We may need to get PIAA Data Sharing Project information to determine the issue.

There is a growing body of research being done on EHRs and physician burnout. It is important to realize how the EHRs have impacted burnout levels and professional fulfillment levels in our providers. And what might have been thought of as something that was going to be a time saver may actually end up as something that is also causing duress

for our providers.

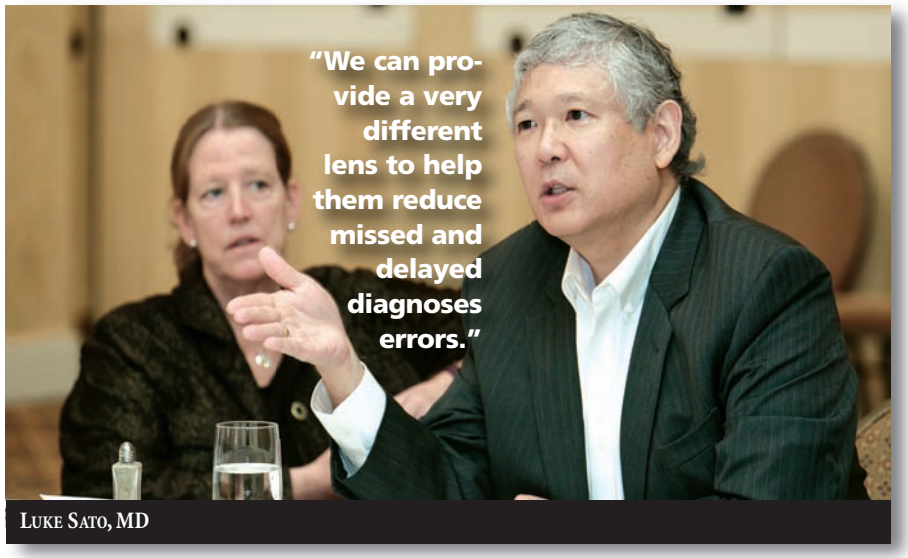
Patients often complain about a lack of interaction because the doctor is so busy looking at a screen, rather than talking to them. It really is important for providers to understand that they need to be able to step away from the screen and actually interact with the patients.

IML: Has claims experience changed with EHRs?

Sato: These EHRs are meant to provide a lot more data and information to the healthcare providers in real-time. The benefit is that it provides the needed information very quickly at point of care. But the downside is that people are experiencing the phenomenon of "too much information." The critical issue is, how can information be provided and displayed to the clinicians in a way the helps their workflow and workload without overwhelming their senses. We would like to work with the EHR vendors to address this problem.

So I think that that's a risk from our perspective: when you're offered so much information, we humans are bound to miss, not know, or not be aware what information is relevant such as critical test results or a referral that needs follow-up.

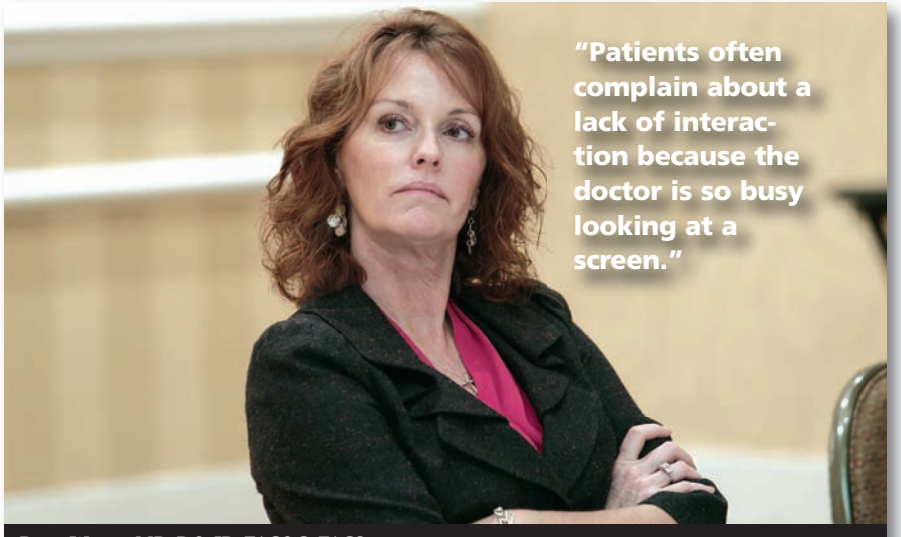
Currently, the responsibility is on the provider to look through the medical record to find labs and other results and quickly decide what's important and not important. To date, we've mostly relied on the humans for this task, but I feel very strongly that as technology improves, we're going to have to find ways that technology could help with this process.



LUKE SATO, MD

Welle: Our overall claims have not changed because of EHRs. We have seen a couple of claims that are related to the EHR, or where the EHR is mentioned in the claim, but the data is not sufficiently conclusive to say what's actually going on.

IML: How are you approaching risk management with your insureds when it comes to EHRs and IT?



DANA WELLE, MD, DO, JD, FACOG, FACS

Sato: What we have done is to develop a process-of-care framework that focuses on the diagnosis processes and analyze and assess where EHR or HIT could help mitigate risk in each step of the process. This way, we can provide clear recommendations to our constituents, as well as identify risk around specific areas where they are vulnerable from the technology perspective.

So I hope the value that we can bring is to provide a very different lens to help them reduce missed and delayed diagnoses errors, which as you know are very expensive—not just to us, but also to the defendant. It's devastating, to get served with a case and suddenly become involved in a lawsuit.

Welle: We have a somewhat different approach. In our organization, we recently went about a rollout of a replacement EHR system. There was a lot of training, coupled with education on safety and quality. In our hospital, when they implemented EHRs, they changed their staffing ratios, and the clinics changed the number of patients they were seeing. So in regard to risk management, it is important to be proactive—to decrease the risk around EHRs.

We do have conversations with our physicians because the EHR allows the cut-and-paste feature, to try and move them away from cutting and pasting, and instead enter more original content to accurately capture the provider patient interaction.

Intergenerational Differences

IML: What are the challenges for MPL insurers when providing coverage for younger healthcare professionals?

Billingham: If you look at it from a business perspective, one of the greatest challenges facing the MPL carriers is that the majority of the younger physicians are going to become employees of a self-insured vehicle such as a hospital.

Drill-Mellum: We don't see particular challenges in underwriting younger physicians. We're thrilled to underwrite them. The sooner we get them in, the better.

IML: What are the differences you are seeing with associated risks?

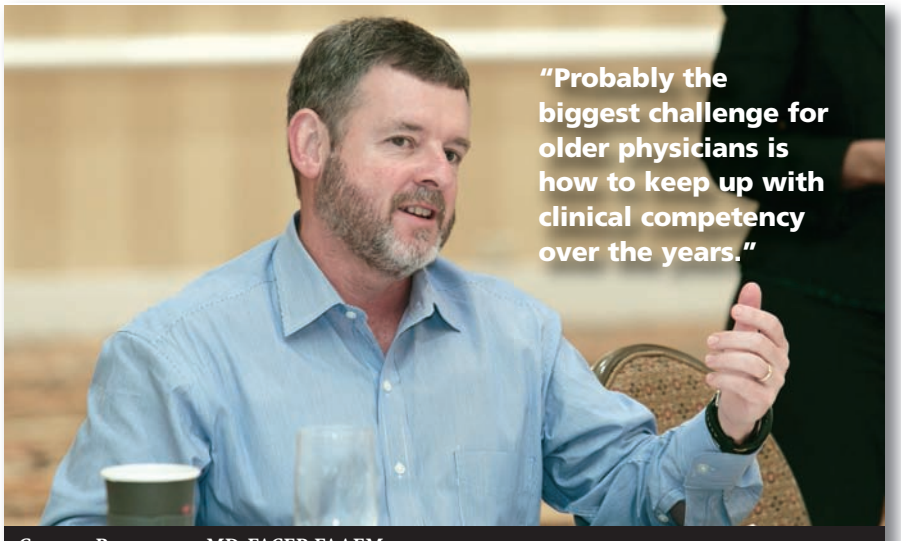
Billingham: From a risk perspective, there are a couple of interesting observations about the younger generation: They learn very quickly, and they are very technology savvy. They readily use and embrace social media, texting, and smart technology while taking care of patients. Although this is good in many ways, it also has the potential to lead to HIPAA breaches or cyber-attacks that compromise PHI [protected health information] and other sensitive information.

Laurie Drill-Mellum, MD, MPH

Further, the younger generation has somewhat of a dependence on technology. An example is surgical training; many young surgeons are trained in robotic surgery or laparoscopy. They're very technically competent, and they are used to using the laparoscope. However, if a complication occurs, they have less experience converting from a minimally invasive approach to a traditional open approach. MedPro's General Surgery Specialty Advisory Board has discussed how older surgeons were traditionally trained and how many of the procedures were open. Now, many surgical procedures are done through a scope, which presents new risks.

That's just one example of the difference in training and the utilization of technology. Another example is diagnostic work: the younger doctors with less clinical experience tend to do a lot of imaging on patients. Probably the biggest challenge for older physicians is how to keep up with clinical competency over the years. We have physicians practicing into their 70s. How do we make sure that they can do certain procedures—some of which may be high risk—especially if they don't do them all of the time?

That's why you see advances in training, such as simulation training—I think that's a good change. But I also think that it's important to evaluate competency as physicians get older. Hospitals that have healthcare professionals practicing into their seventies might need to consider various issues as part of credentialing, such as whether older practitioners have adequate stamina, dexterity, hand–eye coordination, vision, and more. This will be an interesting issue to monitor.



Graham Billingham, MD, FACEP, FAAEM

IML: Has your claims experience differed for the two age groups?

Drill-Mellum: We looked at data on our covered physicians in five-year age bands recently, and we found that the percentage of total claims generated by each age band tracks pretty closely with the percentage of our total insured physicians in that age band, with a couple of exceptions.

Overall, the highest number of claims occurs among physicians between ages 35 and 64. That is also when physicians are their

busiest—they're doing the most work and have the largest patient panels. So it's not surprising to see this.

It's also not surprising that physicians just starting their careers have fewer claims, proportionally. They haven't built large patient panels yet, and also, claims can sometimes take several years to develop.

Things get more interesting when we look at late-career physicians.

Starting about age 60, they comprise a smaller portion of our insured population, about 7%, and that number decreases to less than 1% for physicians past age 80. But these groups are over-represented in our claims.

Billingham: That's a very interesting question. Hard science is somewhat lacking, but let me share some observations. Risk seems to vary more based on specialty than based on age.

It's probably safe to say that someone who is less experienced might be more susceptible to technical skill or performance issues. But, by the same token, a very seasoned physician might be susceptible to certain cognitive biases, such as overconfidence. In other words, they have so much experience that they rely a lot on their intuition and judgment. I think that these are two important issues to monitor in claims trends.

Our general finding is that frequency peaks for physicians in their fifties and declines with age over 60. Presumably, that's due to doctors winding down their practice; they might not see quite the volume that they did prior to age 60. Also, there doesn't seem to be a measurable change in severity of claims with age.

IML: Have you drilled down to find out the reason?

Drill-Mellum: We haven't done a deep analysis of the data yet, so it's early to impute causation. But there are contributors of loss for everybody. There are technical performance issues. There are cognitive error issues. I can't tell you that in the older group, there are technical performance issues versus somebody a few years younger. On the other hand, I can speculate that my younger colleagues are better at flipping their schedules around—pulling nights and days—and more practiced at some of the new technologies than I am.

IML: How does your risk management approach differ in terms of younger vs. older healthcare professionals?

Billingham: What's clear to us, as a malpractice carrier, is that physicians in all age groups are requesting more electronic content. Digital content allows them to access the materials at their convenience. Yet, some still prefer in-person conferences and hard-copy materials.

Typically, though, the younger physicians prefer social media and immediate access. Across MedPro's specialty advisory boards, for example, the younger physicians will use platforms like Twitter, whereas the older physicians don't. The younger generation is communicating patient safety and risk management information using social media.

My general perception is that the older physicians place more value on face-to-face interactions and printed materials—although, I would say that this trend is changing over time. To effectively provide risk management education, I think MPL insurers have to provide programs and content in a variety of formats. Further, regardless of age, everyone learns differently, which necessitates multiple formats.

Additionally, a growing concern for MPL companies is "sub-specialization." Healthcare professionals tend to like seeing certain types of patients and doing certain types of procedures.

Drill-Mellum: Our risk management approach is evolving as we see technology play a greater role in medical care and communications. As a general rule, younger physicians are more dependent on technology, and leverage it more. That has upsides and downsides.

There is a lot to be gained from the use of technology. But over-reliance on technology and under-reliance on the history and physical exam, and face-to-face communication, can lead to problems.

Take the problem of false negatives. I was at the 2013 PIAA Claims/Risk Management Workshop in Seattle and a radiologist there said that the rate of initial false negative readings of CT scans is 17% to 19%.

We see that in our claims. I recall an elderly patient with abdominal pain. She had a history of kidney stones, which was noted on the x-ray requisition. The radiologist simply recorded "kidney stone," and did not note early signs of swelling around the appendix, because the CT scan was read as negative with respect to the appendix. The young doctor over-relied on that negative, which was ultimately false. She didn't go back to the radiologist and say, "This person still has abdominal pain, which is getting worse—what do you think?" She didn't get a surgery consult.

This patient languished in the hospital for three days, at which point her appendix ruptured. All sorts of complications ensued.

That's a perfect example of over-reliance on technology coupled with an under-reliance on the physical exam and history—and that can happen to any physician, old or young. I think the attempt to categorize physician risk by age may be a bit of a red herring. All age groups can have problems communicating. And we are concerned about certain practices that cross all ages, such as unsecured texting of what should be HIPAA-protected patient information. All physicians do that now. Residents are texting information to their attendings at home. ER docs are texting photos or echocardiograms to consultants at home, because it's easier, and it's quick. I don't think that's generational.

I will say that the way we deliver our risk management services is changing. We are making more of our risk education program available online 24/7, because we know that, in general, younger physicians are interested in online CME and education. PIAA

Editor's Note: Look for Part Two, on the evolving role of the CMO, in the Second Quarter 2016 issue.